12-1800-17355-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Determination of Maltreatment and Order to Forfeit a Fine for Access of the Red River Valley, Inc.	**FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Steve M. Mihalchick at 9:30 a.m. on October 2, 2006, at the Moorhead City Hall Conference Room, 500 Center Avenue, Moorhead, Minnesota. The hearing was held pursuant to a Notice of and Order for Pre-hearing Conference June 26, 2006. Theresa Meinholz Gray, Assistant Attorney General, 445 Minnesota Street, Suite 900, Saint Paul, MN 55101-2127, appeared on behalf of the Department of Human Services ("the Department" or "DHS"). Dan Plambeck, Attorney at Law, Stefanson Law, P.L.L.P., 403 Center Avenue, Suite 302, Moorhead, MN 56561, appeared on behalf of Access of the Red River Valley, Inc. ("Access"). The hearing record remained open at the conclusion of the hearing for submission of posthearing briefs and replies. The hearing record closed on November 14, 2006 with the receipt of the reply briefs.[1]

NOTICE

This report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact Cal R. Ludeman, Commissioner, Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155 to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

[1] DHS moved to strike a portion of Access' reply brief. The motion was denied by the ALJ on November 21, 2006. The motion does not affect the closing date of the record.

Under Minn. Stat. § 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

STATEMENT OF ISSUES

Did the Department of Human Services appropriately determine that Access, as a facility, was responsible for the maltreatment of a vulnerable adult (VA) under Minn. Stat. § 626.5572, subd. 17(a), that occurred on January 2, 2004 and impose a $1,000 fine? Specifically, was Access culpable of neglecting a VA by failing to adequately supervise the VA when the VA sexually assaulted the Access staff person providing care on that date?

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. Access of the Red River Valley, Inc. ("Access") is a non-profit organization run by an Executive Director, Sharon Staton, and overseen by a Board of Directors. Access is an adult foster care provider licensed by the Department. Access provides adult foster care services in each client's own residence. In 2003, Access was serving 25 adults and 130 children in different programs.[2]

2. R.B. suffered from juvenile onset diabetes.[3] In 1999, R.B. entered a diabetic coma. As a result of the brain trauma suffered in the coma, R.B. now lacks a significant degree of impulse control.[4] Because of R.B.'s brain trauma, he is a vulnerable adult under Minn. Stat. § 626.5572. R.B. is male, is approximately 6 foot 2 inches in height, weighs 240 pounds, and has no physical disabilities. R.B. is at a relatively high mental functioning level, with his disabling condition arising from mood and impulse control problems. Prior to the coma, R.B. had been in college, maintained a relationship with a girlfriend, and had a daughter.[5] R.B.'s relationship ended after the brain trauma and his visitation with his daughter is now supervised. R.B.'s mood and impulse control problems were considered to be exacerbated by R.B.'s bi-polar disorder.[6]

3. R.B. began receiving services from Marshall County Social Services ("the County") due to his disabling condition in 2000. Brian Lehman, a case manager for the County, was responsible for determining client needs and

[2] Testimony of Staton, Tape 9, Side 1; Ex. 37.
[3] Testimony of Lentz, Tape 7, Side 2.
[4] Testimony of Lehman, Tape 4, Side 1; Testimony of Odden, Tape 8, Side 2.
[5] There is some conflict in the record as to whether R.B. graduated from college and whether he was married prior to the coma. There is no dispute that the effects of the coma rendered R.B. disabled and the relationship dissolved.
[6] Testimony of Cody, Tape 3, Side 1; Testimony of Lentz, Tape 7, Side 1; Testimony of Odden, Tape 8, Side 2.

arranging services. R.B. was living at the home of his parents in Middle River, Minnesota. R.B.'s parents began expressing concern to Lehman that they could no longer care for R.B.[7]

4. Lehman obtained approval for placement at the Brainerd State Hospital where R.B. resided for almost one year. Prior to coming to Access, R.B. acted out, throwing a chair through a window.[8] There were also situations in which R.B. had harmed himself in the hospital placement.[9] Lehman inquired into a number of placement options that were less restrictive than the hospital placement. No group home placements were available at that time. On October 22, 2002, R.B. began receiving services from Access.[10]

5. Access staffers provided supervision of R.B. especially in the areas of ensuring that he take appropriate medication and that he maintain an appropriate diet. R.B. did not need staffers to assist in performing activities of daily living, but R.B. did need prompting in a number of areas and staffers were to provide that prompting.[11]

6. In addition to receiving care from Access, R.B. worked at a job in a support agency.[12] Within a few months of beginning care with Access, R.B. began to have behavioral problems, particularly with respect to maintaining appropriate diet.[13]

7. Access workers had a policy book available to them that addressed questions about services to be provided to particular clients. Normally, the qualified mental retardation professional (QMRP) assigned to a client and the Access scheduler would address staffing issues.[14]

8. Patty Cody has been a social worker with Prairie St. Johns (a medical facility in Fargo) since July 2005. Cody worked for Access from May 1998 until June 2005. With Access, Cody served as QMRP managing cases of developmentally disabled adults and supervising direct care staff who were providing adult care services. In December 2001, Cody was promoted to the position of Adult Services Director. As Director, Cody was supervising three QMRPs, each averaging eight clients.[15]

9. Cody supervised the QMRPs who worked with R.B. Due to turnover, Cody occasionally provided QMRP services to R.B. on a fill-in basis. Cody indicated that 24-hour supervision was required for R.B. due to the terms of

[7] Testimony of Lehman, Tape 3, Side 1
[8] Testimony of Cody, Tape 1, Side 2.
[9] Testimony of Lehman, Tape 4, Side 1.
[10] Testimony of Lehman, Tape 3, Side 1.
[11] Testimony of Lehman, Tape 3, Side 2.
[12] Testimony of Lentz, Tape 7, Side 1.
[13] Testimony of Cody, Tape 1, Side 2.
[14] Testimony of Cody, Tape 1, Side 2.
[15] Testimony of Cody, Tape 1, Side 2.

the County waiver.[16] R.B. required assistance with his medications and with diet. R.B. was not capable of dealing with his own finances.[17]

10. K.M. (a female staffer) began working with Access in August 2002. She worked for Access until early September 2003. During this period, K.M. did not provide services to R.B.[18]

11. Renee Birnbaum is a direct care staffer for Red River Human Services and Family Link. Birnbaum's responsibilities include teaching living skills and providing supervision for handicapped children and adults. She has worked in this area since 2002. Birnbaum for Access from 2002 to 2004. With Access, she provided supervision and taught living skills including financial management. Birnbaum left work with Access due to a dispute over attendance.[19]

12. Birnbaum worked on a floating schedule with R.B. from October 2002 through 2004.[20] R.B.'s behavior was initially positive with Access staffers. Over time, R.B. became more resistant to the programming established by Access. This behavior included refusing medication. Throughout 2002 and most of 2003, Access supervised R.B. using a single staff person.[21]

13. Sheila Lentz, RN, has worked for Access for 14 years. Lentz was on the team that assessed R.B. for participation in the program. Team meetings were held periodically to assess R.B.'s progress and address issues regarding delivery of services to R.B. In performing her duties for Access, Lentz was occasionally alone with R.B., particularly when transporting R.B. to and from medical appointments.[22]

14. R.B. received services under a plan that directed some activities of daily living and provided supervision by staff while in R.B.'s apartment and on various trips (grocery store, movies, etc.). Staff were instructed to redirect R.B. if he wanted to go somewhere without supervision, but staff had no authority to stop R.B. if he wished to go out alone.[23] R.B. was in possession of a driver's license although his access to automobiles was limited.[24]

15. R.B.'s apartment had two bedrooms, one was R.B.'s bedroom and the other used as a staff room, containing a bed, a desk, and a file cabinet. The room was equipped with a lock. The lock was the type typically installed on bathroom doors, with a hole in the outside knob that allowed the door to be

[16] Testimony of Cody, Tape 1, Side 2.
[17] Ex. 31; Testimony of Cody, Tape 1, Side 2.
[18] Testimony of K.M., Tape 4, Side 1 and Tape 5, Side 1; Ex. 35, Attachment 2.
[19] Testimony of Birnbaum, Tape 1, Side 1.
[20] Testimony of Birnbaum, Tape 1, Side 1.
[21] Testimony of Birnbaum, Tape 1, Side 1.
[22] Testimony of Lentz, Tape 7, Side 1.
[23] Ex. 15; Testimony of Birnbaum, Tape 1, Side 2.
[24] Exs. 14 and 31.

unlocked with a thin tool or device. The living area was divided between a main room (containing a couch, love seat, and entertainment center) and the kitchen. There was only one door opening onto the hallway outside the apartment.[25]

16. On July 10, 2003, R.B. was hospitalized in the MeritCare psychology unit in Fargo, N.D. That hospitalization lasted until August 20, 2003 to address R.B.'s mood problems. On August 20, 2003, a diagnostic assessment was performed by the Access psychologist, Ronald Odden.[26] A discharge meeting was held prior to returning R.B. to his apartment with care provided by Access. The treating physician questioned whether the supervised living arrangement was appropriate for R.B., given his problems with mood control. The consensus of the team meeting was for R.B. to return to his apartment and continue receiving services from Access.[27]

17. On October 27, 2003, R.B. was brought to the emergency room for refusal to take his insulin. The treating physician directed that R.B.'s driving license should be removed for public safety reasons and the R.B. not have unrestricted access to the contents of his refrigerator. A lock was proposed to prevent unsupervised access. The physician suggested that a more structured environment was a possibility that should be explored.[28]

18. In November 2003, Access hired Gretchen Bunker, LSW, working as R.B.'s QMRP and providing direct services to R.B. three times a week.[29] R.B. responded poorly to Bunker and R.B. often acted out in a threatening manner in her presence.

19. On November 3, 2003, R.B. made a follow-up visit to Dr. Sand (to review progress after the October 27, 2003 emergency room visit). Dr. Sand noted that R.B. was "belligerent to staff, inappropriate, and has no insight or alleged memory of being seen in the emergency room or that he is having problems."[30] Dr. Sand concurred that R.B. should not have a driving license and that his access to the contents of his refrigerator be restricted.

20. On November 10, 2003, R.B. quit his job. Later that day, R.B. was being cared for by a staff member, Chris Duke, and Lentz was on site preparing medications to be taken later. Duke and R.B. began arguing over whether R.B. was going to work the next day. R.B. began striking Duke. R.B. began choking Duke and Lentz intervened by telling R.B. to stop. R.B. stopped and began crying. R.B. went to his bedroom of his own accord. The police were called.

[25] Ex. 3, DHS 72.
[26] Ex. 23; Testimony of Odden, Tape 9, Side 1.
[27] Testimony of Lehman, Tape 3, Side 2.
[28] Ex. 14.
[29] Testimony of Bunker, Tape 5, Side 2.
[30] Ex. 14.

Duke was injured in that assault and he swore out a complaint against R.B. R.B. was not physically injured in the assault.[31]

21. On November 19, 2003, a Behavioral Intervention Plan was developed by R.B.'s psychologist to address R.B.'s conduct. Checklists for a.m. and p.m. tasks were drawn up, with cigarettes and "alone time" of up to one hour were provided as rewards for completing the checklists daily.[32] In a section entitled "Other Procedures", staff were instructed that:

> If [R.B.] becomes verbally threatening, staff should give one verbal prompt in a matter-of-fact tone, "You need to stop threatening", then leave the room.
>
> If [R.B.] escalates to physically threatening staff, staff should remove themselves from the situation – either going to the staff room and locking the door or leave the apartment. Then call the on-call person so that [R.B.] can be confronted by more than one staff. If he has escalated to throwing furniture or actually having attempted to harm staff – get to safety and call the police.

22. On November 20, 2003, R.B.'s assessment team held its annual meeting. The team was comprised of Cody, R.B.'s mother, Lehman, Odden, Lentz, Bunker, and R.B. The team discussed R.B.'s recent behaviors and his quitting his job. The criminal charge against R.B. was discussed and his upcoming court appearance in that matter was noted. The new Behavior Intervention Plan was discusses and agreed to by the team. No discussion was held regarding increasing staffing as a result of R.B.'s recent behaviors.[33]

23. On November 25, 2003, R.B. left the apartment (by taxi) and went bar-hopping, which left Bunker following R.B. to bars. Bunker tried to talk R.B. out of going and R.B. was verbally threatening to Bunker.[34] Bunker telephoned Cody and expressed her discomfort with what R.B. was doing.[35] Cody told Bunker to go along and they were at the bar until closing time. Upon returning to R.B.'s apartment, R.B. again threatened Bunker to the point where Bunker left at about 3:00 a.m. After consulting with Cody again, Bunker went home and returned at about 5:00 a.m. to provide supervision. R.B. did not suffer any ill effects from the outing other than a hangover from consuming alcohol. R.B. did not regularly consume alcohol. [36]

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[31] Testimony of Lentz, Tape 7, Side 1.
[32] Testimony of Odden, Tape 8, Side 2.
[33] Ex. 35, DHS 551; Testimony of Lehman, Tape 3, Side 2; Testimony of Odden, Tape 9, Side 1.
[34] Testimony of Bunker, Tape 5, Side 2; Testimony of Lehman, Tape 3, Side 2.
[35] Testimony of Cody, Tape 2, Side 1.
[36] Testimony of Bunker, Tape 5, Side 2; Ex. 16. There is, however, a reference to continuing in Alcoholics Anonymous in a service contract between Access and R.B. Ex. 22.

24. At the beginning of December 2003, K.M. returned to work with Access and began providing services to R.B.[37] K.M. was emphatically advised that R.B. regularly engaged in verbally aggressive behavior, and had recently engaged in an instance of assaultive behavior. The training that K.M. received regarding R.B. was directed toward redirecting physical behaviors rather than de-escalating R.B.'s inappropriate impulses or mood. The training took place in a large group of Access staffers and was conducted by Cody and another professional.[38]

25. As part of her orientation for providing services to R.B., K.M. reviewed R.B.'s Behavior Intervention Plan. K.M. characterized the approach in that plant to R.B.'s behaviors as "redirect, ignore, leave."[39] K.M. and other staffers were occasionally confused about how R.B.'s Behavioral Intervention Plan was to be implemented in certain situations, consistent with the staffers' supervision responsibilities. K.M. had been told previously, while providing supervision for a different client, that leaving a client unsupervised would result in a vulnerable adult maltreatment finding against K.M. personally.[40] There is no evidence that K.M. requested a clarification from anyone at Access.

26. On December 1, 2003, a meeting was held to discuss R.B.'s behavior and what could be done to address the problems that had arisen and avoid situations where R.B. was unsupervised. The meeting was not a formal assessment meeting, but was attended by R.B.'s mother, Bunker, and Cody.[41] Lentz was not involved in the meeting.[42] Odden spoke to Cody regarding double staffing. No assessment team meeting was held to formally change R.B.'s plan to require double staffing. Increasing the assigned staff in the evening and overnight from one to two ("double staffing") was decided upon as a means of ensuring that R.B. was not engaging in binge eating and that he would not leave his apartment to go to bars. The safety of staff was another concern addressed at the meeting.[43]

27. On December 2, 2003, Access instituted double staffing for R.B.[44]

28. On December 3, 2003, Bunker and another staffer were at R.B.'s apartment. Bunker was sleeping in the staff room and the other staffer had fallen asleep on the couch. R.B. awoke the staffers, saying that he had swallowed cleaning products in an effort to kill himself. Bunker called Cody and was told to

[37] Testimony of Kelly, Tape 8, Side 1.
[38] Testimony of K.M., Tape 4, Side 1; Ex. 35, Attachment 2.
[39] K.M. Tape 4, Side 2.
[40] K.M. Tape 4, Side 2; Ex. 32.
[41] Ex. 16, DHS 212.
[42] Testimony of Lentz, Tape 7, Side 2.
[43] Testimony of Bunker, Tape 5, Side 2 and Tape 6, Side 1; Ex. 16.
[44] Ex. 30.

take R.B. to the hospital emergency room. R.B. was evaluated by medical staff.[45]

29. Access developed "pointers" for staff to use while supervising and providing services to R.B. He was only to be taken to the emergency room if he displayed actual symptoms of distress. R.B.'s manipulative behavior was noted and the false claim of drinking cleaning products cited as an example of that behavior. The effect of his bi-polar disorder on R.B.'s conduct at different times of the day was described. For manic periods, staff were advised to avoid arguments and interaction, go to the staff room, wait while R.B. calms down, and maintain awareness of where he is and what he is doing. When R.B. refuses to check blood sugar or take insulin, staff were to try again in 15 minutes and, if unsuccessful, to contact the on-call staff. The approach to R.B.'s manic behavior was summarized as: "1) Redirect 2) Ignore and 3) Go to Staff Room."[46]

30. On December 5, 2003, Access held a staff meeting to discuss the R.B. situation. Reference was made to paying direct staff $8.00 per hour for providing services for R.B., due to challenging nature of duties.[47] The increase of the hourly rate was the standard practice of Access when clients presented challenging behaviors.[48] K.M. recalled the discussion of double staffing as being for R.B.'s protection by ensuring that he was not engaging in binge eating (which could affect control of his diabetes) and that he was not harming himself. K.M. understood that double staffing was to permit one staffer to sleep while the other remained awake. Prior to double staffing, the single staffer would sleep on the overnight shift.[49]

31. K.M. noted that R.B. was not as antagonistic with single staffing as with double staffing. She considered him "more laid back" with single staffing. R.B.'s bipolar disorder manifested in his mood ranging from low to happy, with R.B. playing games and chain smoking. R.B. was actively rude to Bunker and he exploited Bunker's unease and relative inexperience as a QMRP. No matter who was staffing, R.B. made a point of making clear to each staffer that he was physically stronger than the staffer. [50]

32. On December 12, 2003, Cody transmitted a request for approval of double staffing to Lehman, effective December 2, 2003. Lehman approved double staffing, anticipating that it would be used on a temporary basis to address R.B.'s behaviors. Lehman expected to check back in January 2004 to determine if double staffing remained needed and when it could be discontinued.[51]

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[45] Testimony of Bunker, Tape 5, Side 2 and Tape 6, Side1; Ex. 17.
[46] Ex. 25.
[47] Ex. 35, DHS 553; Testimony of Bunker, Tape 5, Side 2.
[48] Testimony of Hanenberg, Tape 7, Side 1.
[49] Testimony of K.M., Tape 4, Side 2.
[50] Testimony of K.M., Tape 4, Side 2.
[51] Testimony of Lehman, Tape 3, Side 2.

33. K.M. and other staffers were occasionally confused about how R.B.'s Behavioral Intervention Plan was to be implemented in certain situations, consistent with the staffers' supervision responsibilities.[52]

34. Julie Hanenberg, the onsite coordinator for Access, was responsible for arranging direct care staff for clients. She occasionally received feedback from staffers regarding care of clients. In mid-December, two staff members, Joe Quinn and Mike Meagher, who provided supervision to R.B. told Hanenberg that double staffing was not working for R.B. Hanenberg mentioned this to Birnbaum and K.M., who both agreed that R.B. was not responding to double staffing. All of these staffers told Hanenberg that they were comfortable working with R.B. on a single staff basis.[53]

35. In mid-December, K.M. left a voicemail message for Cody that R.B. was playing one staff member off against another and (in K.M.'s opinion) double staffing for R.B. should be discontinued.[54] K.M. characterized the situation as "double staffing is not working."[55] Several other staff members made similar comments about the double staffing for R.B.[56] K.M. made similar comments to others at Access.[57]

36. On December 16, 2003, K.M. and Bunker were providing supervision for R.B. After being asked to take his medication, R.B. began shouting about how he was an adult and should not be told what to do. R.B. called the police. When the police responded, R.B. demanded that K.M. and Bunker be removed from his apartment. The police officers explained that they could not remove the staffers because R.B. was receiving services. R.B. stated that he would "beat them [K.M. and Bunker] up" so that the police would arrest him and remove him from the apartment. R.B. calmed down and the police officers left. After the police officers left, R.B. threatened to break Bunker's back and leave her in a wheelchair. Bunker went to the staff room and K.M. spoke to R.B. about calming down and taking his medication.[58]

37. K.M. noted a number of occasions where R.B. made threats of harming staff, occasionally displaying knives. K.M. observed that being matter of fact and changing the subject tended to get R.B. to change the subject and de-escalate. K.M. observed that better outcomes were obtained by not "feeding into

[52] Testimony of K.M. Tape 4, Side 2.
[53] Testimony of Hanenberg, Tape 7, Side 1; Ex. 35, DHS 557.
[54] Testimony of Cody, Tape 2, Side 1. Cody later memorialized this voicemail in a memorandum that was backdated at the request of Access management. Ex. 35, Attachment 9. Testimony of K.M., Tape 5, Side 1.
[55] Testimony of K.M., Tape 5, Side 2.
[56] Testimony of Cody, Tape 2, Side 1.
[57] Testimony of K.M., Tape 5, Side 1.
[58] Testimony of K.M. Tape 4, Side 2; Ex. 19; Testimony of Bunker, Tape 5, Side 2..

the situation" by the staffer responding emotionally. K.M. observed that much of the conflict occurred between R.B. and Bunker.[59]

38. On one occasion when K.M. and Bunker were working overnight, R.B. watched a "Girls Gone Wild" video, which involved women suggestively disrobing. R.B. made sounds indicating that he was masturbating to the images in the video. K.M. was awake at this time and she avoided making any comment about R.B.'s conduct to him. K.M. had been instructed that such behavior is within a VA's rights.[60] When Bunker awoke, K.M. related the incident. There is no indication in the record that R.B. was directing his actions toward the supervising staff. None of the staff felt intimidated or threatened by this incident.

39. Access had trouble staffing services for R.B. in December 2003. R.B. was unemployed at this time, increasing the need for staff during the day.[61] R.B. originally scheduled to be with his mother for two weeks beginning on December 23, 2003.[62]

40. R.B.'s mother called Lentz after R.B. began his two weeks away from the program. As related by his mother, R.B. was seeking to drive her car to bars and she was going to back to work soon. R.B.'s mother expressed concerns about leaving R.B. unsupervised during the day.[63] Due to her experiences with R.B.'s behavior, she asked Lentz if R.B. could return to his apartment (under supervision by Access) earlier than scheduled.[64]

41. Lentz spoke to Hanenberg and Cody regarding R.B. returning to determine if staff was available to staff R.B.'s apartment.[65] Due to the unanticipated return of R.B., staff assignments had not been made to provide care for him in late December and early January. Most of the unassigned direct care staff were college students and many of them had already left for the holidays. Hanenberg called Staton to determine what should be done regarding R.B.'s proposed return to Access. Hanenberg was instructed by Staton to "do what it takes" to staff R.B.'s site. Hanenberg was authorized to offer double pay as an incentive to get staff to agree to work over the holiday period. There was no perception by Hanenberg or Staton that this additional money was compensation for any possible risk posed by R.B.[66] Staton returned to Moorhead early from a family vacation to address this situation.[67]

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[59] Testimony of K.M. Tape 4, Side 2.
[60] Testimony of K.M. Tape 5, Side 2.
[61] Testimony of Cody, Tape 2, Side 1.
[62] Ex. 24, DHS 292; Ex. 46, December 2003 Schedule; Testimony of Lentz, Tape 7, Side 2.
[63] The date of the call was not included in the record. From the context, the call appears to have been made shortly after Christmas.
[64] Testimony of Lentz, Tape 7, Side 2.
[65] Testimony of Lentz, Tape 7, Side 2.
[66] Testimony of Hanenberg, Tape 7, Side 1.
[67] Testimony of Staton, Tape 9, Side 2.

42. Bunker terminated her employment with Access in late December. To provide staffing, Staton indicated that staff members should be asked if they were comfortable providing care on a single staff basis. Staton was aware that a number of staff had expressed a preference for working alone with R.B. Staton said that staffers could be offered double pay to cover shifts with R.B.[68] K.M. perceived the offer of a bonus was to work on a single staff basis, rather than staffing over the holiday.[69] Odden was not informed that supervision was to be provided to R.B. on a single staff basis. Odden's preference was for double staffing, but that was for the protection of staff, not R.B.[70]

43. Birnbaum indicated that she was available in late December, 2003. Julie Hanenberg asked Birnbaum if she had any problem working with R.B. Hanenberg offered to pay Birnbaum double to work alone with R.B. Birnbaum did not consider working with R.B. to be particularly risky. Birnbaum considered obtaining adequate staffing to be difficult for any of the VAs served by Access, due to the nature of the work. [71]

44. R.B. returned to the Access program on December 28, 2003.[72] On his return, his blood sugar was tested. Lentz found that R.B.'s blood sugar was very high.[73]

45. Birnbaum worked alone with R.B. on various shifts from December 29 through December 31, 2003. On overnight shifts, staff understood that they could sleep. Birnbaum would take a sweat suit to sleep in, using the staff room in the VA's apartment. The staff room included a bed, with bed linens in a closet. The normal "daytime" rate for Birnbaum was $8.00 per hour and Access paid $5.15 per "sleep hour." For the December 29-31 period, Access paid Birnbaum $16.00 for each awake hour.[74] Birnbaum did not use the lock on the staff room door when she was sleeping in the staff room.[75]

46. On December 29, 2003, at about 9:30 p.m., Birnbaum was reading papers in the staff room in the apartment when R.B. appeared in the doorway wearing only boxer shorts. R.B. dropped his shorts to his ankles and asked Birnbaum to provide her opinion as to his penis size. Birnbaum responded by averting her gaze, directing R.B. pull his boxers back up, and telling him that this behavior was inappropriate. R.B. immediately pulled up his shorts and gave Birnbaum no other trouble relating to this incident. Birnbaum spoke to Eva Kelly at Access about the incident. Both of the Access personnel thought that the incident was humorous, not threatening. Birnbaum completed an incident report.

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[68] Testimony of Cody, Tape 2, Side 1; Testimony of Staton, Tape 9, Side 2.
[69] Testimony of K.M., Tape 5, Side 1.
[70] Testimony of Odden, Tape 9, Side 1.
[71] Testimony of Birnbaum, Tape 1, Side 1.
[72] Ex. 24, DHS 293.
[73] Testimony of Lentz, Tape 7, Side 2.
[74] Ex. 47; Testimony of Birnbaum, Tape 1, Side 1.
[75] Testimony of Birnbaum, Tape 1, Side 2.

Birnbaum did not perceive R.B.'s actions to be a problem, and he never acted in a sexual manner around Birnbaum, except for some comments that Birnbaum took to be jokes.[76]

47. On January 1, 2004, Birnbaum worked with R.B. from 8:30 a.m. to 4:00 p.m. There had been no sexual comments from R.B. after the "boxer shorts" incident on December 29, 2003. On the evening of January 1, 2004, K.M. was providing supervision of R.B. As with the entire period since R.B. returned from his mother's house, the supervision was provided by a single staffer. K.M. accompanied R.B. to eat dinner at the pizza restaurant at the mall. R.B. was in a good mood during the outing. R.B. and K.M. played pool at an arcade. They rented movies at the video rental store. While at the store, R.B. made a comment on the penis size of African-American men. K.M. told R.B. that they were not going to talk about such things, and R.B. changed the subject.[77]

48. At the apartment, R.B. watched a movie and K.M. wrote letters. At some point later in the evening, K.M. changed into pajamas. She joined R.B. on the couch to watch the movie, sitting at the far end from R.B. R.B. got behind K.M. and began touching her in a sexual way. R.B. had never acted this way toward K.M. before.[78] K.M. tried to get up and R.B. held her down and continued sexually touching K.M. K.M. repeatedly told R.B. to stop what he was doing. R.B. removed K.M.'s clothing and engaged in forced intercourse. K.M. thought that R.B. might kill her during this assault. K.M. did not describe R.B.'s conduct or manner as being manic or otherwise similar to other conduct when R.B. was out-of-control. [79]

49. After the first sexual assault, K.M. attempted to leave the premises, but R.B. blocked the exit to the apartment. During this time, R.B. made claims the about calling Access and getting K.M. into trouble. K.M. was in shock from the sexual assault and she was confused about what she could do regarding the situation.[80] After a few minutes, R.B. sexually assaulted K.M. a second time. After a period of time, R.B. indicated he wanted to sexually assault K.M. for a third time but she was able to redirect him, saying that they needed to sleep. After R.B. fell asleep, K.M. left the apartment and went to the local clinic for a medical examination and treatment. The sexual assaults took place early on January 2, 2004.

50. After leaving the apartment, K.M. called the on-call number for Access.[81] At the clinic, K.M. indicated that she had been sexually assaulted. The police were contacted and they responded to R.B.'s apartment. The Access

[76] Ex. 20; Testimony of Birnbaum, Tape 1, Sides 1 and 2.
[77] Testimony of K.M., Tape 4, Side 2 and Tape 5, Side 1.
[78] Testimony of K.M., Tape 5, Side 2.
[79] Testimony of K.M., 5, Side 1.
[80] Testimony of K.M., 5, Side 1.
[81] The initial call did not go through (a missed call was on the cell phone log at approximately 5:00 a.m.). Ex. 1, DHS 3. K.M. was able to get through after arriving at the clinic. Ex. 3, DHS 70.

on-call staffer, Jennifer Swanson, and William Smith, a QMRP for Access, responded to K.M.'s call by going to R.B.'s apartment. When they arrived, the door was open. They waited at the apartment until the police arrived. The police arrested R.B. and took him into custody.[82]

51. R.B. was charged and convicted of criminal sexual conduct for the sexual assaults of K.M. He was jailed in Clay County. As a term of his probation, R.B. was placed at the Fergus Falls Regional Treatment Center (Fergus Falls RTC). R.B. violated the terms of his probation by inappropriately touching a female staff member at the Fergus Falls RTC. R.B. is now incarcerated in the Minnesota Correctional Facility in Stillwater, Minnesota.[83]

52. R.B. was also convicted of assault for choking Duke on November 10, 2003. The sentence for the assault was 90 days to be served concurrently with the sentence for the sexual assault.[84]

53. Soon after the sexual assault, the Department of Human Services ("DHS" or Department) received a report of a possible maltreatment/neglect incident, arising from insufficient supervision by Access. DHS initiated an investigation based on that report. The matter was assigned to Cheryl Dietz for investigation. Dietz later left her employment at DHS after preparing a draft report of the investigation. Norman Isaacson, Unit Manager for Investigations for DHS, reviewed information gathered by Dietz and prepared the DHS investigation memorandum relating to the case. [85]

54. In preparing the investigation memorandum, Dietz interviewed Access managers and staff, R.B.'s case manager, and R.B.'s mother. The interviews began on January 12, 2004 and continued to October 2004.[86] Dietz also reviewed the documentation maintained regarding R.B.'s receipt of services from Access.[87] In the course of the investigation, DHS did not identify any actual harm suffered by R.B. The investigation focused on the risk of harm to R.B. That risk included the possibility that a staffer could legitimately fight back in self-defense and thereby harm R.B. The perception of the investigator was that having two staffers present lessened the risk that R.B. would put staff in a situation where they would have possibly harmed R.B.[88]

55. Hanenberg reviewed the staff records for R.B.'s site. These records showed that from December 3, 2003 through January 2, 2004, Access provided double staffing for fourteen days, single staffing for thirteen days, and

[82] Testimony of Smith, Tape 8, Side 1.
[83] Testimony of Lehman, Tape 3, Sides 1 and 2, Tape 4, Side 1.
[84] Ex. 12.
[85] Testimony of Isaacson, Tape 6, Side 1.
[86] Testimony of Isaacson, Tape 6, Side 2.
[87] Ex. 1.
[88] Testimony of Isaacson, Tape 6, Side 2.

no staffing (due to R.B.'s visit with his mother) for four days. The last day of double staffing was December 18, 2003.[89]

56. On February 17, 2005, the investigation memorandum relating to the report regarding Access was issued by DHS. An amended memorandum was issued on June 22, 2006. In the amended memorandum, DHS concluded that maltreatment occurred as follows:

> The VA [R.B.], who had a history of assaultive behavior and required 24-hour supervision, was placed in a situation where s/he had the opportunity to assault the SP [K.M.] and was consequently left alone for more than 35 minutes.[90]

57. On February 17, 2005 (later amended on June 22, 2006), the DHS notified Access that a determination of substantiated maltreatment (neglect) by Access had been made and that Access was ordered to pay a fine of $1,000. The letter and accompanying Investigation Memorandum indicated that the DHS had determined that Access was responsible for the maltreatment of R.B. due to neglect arising from a failure to have adequate supervision of R.B. As part of that determination, the Order stated:

> The VA [R.B.] had previously assaulted a staff person and during the month prior to incident the facility was aware of the VA's increased sexualized and assaultive behaviors. On December 5, 2003, due to the V.A.'s escalating behaviors, the facility decided to assign two staff persons to supervise the VA during the evening and overnight hours. However, the facility failed to provide double-staffing when the VA's plans to stay with family members for the holidays changed. Instead, the SP [K.M.] was offered a $150 bonus to work alone with the VA on January 1 and January 2, 2004. The facility's decision to not provide double-staff supervision to the VA was not based on the needs of the VA, but rather on the difficulty of finding additional staff persons to work during the holiday season.
>
> If the facility had complied with its plan to provide the two staff person supervision that was deemed necessary, the physical intimidation and sexual assault of the SP, the subsequent lapse in supervision, and the resulting criminal charges against the VA, would most likely not have occurred.[91]

58. Access was informed of its right to request reconsideration of the maltreatment determination and its right to request a contested case hearing.[92]

[89] Ex. 35, DHS 549-550.
[90] Ex. 1, DHS 8.
[91] Ex. 33.
[92] Ex. 33.

On March 2, 2005, Access requested a contested case hearing on the Order imposing the fine.[93]

59. On March 9, 2005, Access requested reconsideration of the determination of maltreatment based upon assertions that the DHS findings were inaccurate and incomplete. Access maintained the double staffing was not necessary for R.B. since he had not been exhibiting the behavior that had triggered the change to double staffing. The bonus paid by Access was asserted to be for holiday staffing, not to make up for understaffing at a location. The behavior plan for R.B. expressly called for any staffer being threatened to leave. Access maintained that there was no reason for K.M. to be confused about the proper course for any staffer threatened by R.B. Access argued that the single most important factor was not supervision, but R.B. committing a crime. Access maintained the leaving R.B. alone for 35 minutes as a response to an assault on a staffer could not constitute neglect.[94]

60. On September 14, 2005, DHS denied the request for reconsideration by Access and determined that a preponderance of the evidence showed that the facility was responsible for maltreatment of R.B. In accordance with Minn. Stat. §§ 245A.08 and 626.557, subd. 9d(f), the maltreatment determination appeal and the appeal of the fine were combined in this proceeding.[95]

61. The present contested case proceeding was initiated by the Department by filing a Notice and Order for Pre-hearing Conference on June 26, 2006.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Administrative Law Judge and the Commissioner of Human Services are authorized to consider an appeal of the fine assessed for violating the adult foster care licensing rules, pursuant to Minn. Stat. §§ 245A.07, subd. 3(b), and 14.50.

2. Access received due, proper and timely notice of the basis for the agency's decision, and of the time and place of the hearing. This matter is, therefore, properly before the Commissioner and the Administrative Law Judge.

3. Minn. Stat. § 626.5572, subd. 15, defines "maltreatment" as, among other things, neglect as defined in subdivision 17 of that statute. "Neglect" is defined in pertinent part as:

[93] Ex. 36. The appeal taken from the first Order, issued in February 2005, is effective for appealing the Amended Order.
[94] Ex. 35.
[95] Ex. 36.

> (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
>
> (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
>
> (2) which is not the result of an accident or therapeutic conduct.[96]

4. There has been no showing that the supervision provided by Access on January 2, 2004 in any way adversely affected the VA's physical health or mental health or safety.

5. The absence of any adverse affect on the VA's physical health or mental health or safety while supervision is being conducted demonstrates that no neglect occurred on January 2, 2004.

6. The VA's Behavior Intervention Plan expressly authorized staff to leave the VA's apartment should he become assaultive. Leaving the VA's apartment after he sexually assaulted the supervising staff person does not constitute a lack of supervision that could support a finding of neglect on January 2, 2004.

7. With the absence of any neglect, there is no conduct by Access that falls under the definition of maltreatment.

8. The Department must show that it evaluated certain factors in determining the comparative responsibility for the maltreatment between the facility or its employee, as set forth in Minn. Stat. §626.556, subd. 10e: "When maltreatment is determined in an investigation involving a facility, the investigating agency shall also determine whether the facility or individual was responsible, or whether both the facility and the individual were responsible for the maltreatment using the mitigating factors in paragraph (d). Determinations under this subdivision must be based on a preponderance of the evidence and are private data on individuals or nonpublic data as maintained by the commissioner of education."

9. With the absence of any conduct that falls under the definition of maltreatment, there is no possible evaluation of the comparative responsibility of the facility or its employee.

10. The Department did not demonstrate by a preponderance of the evidence that any maltreatment of R.B. occurred on January 2, 2004.

[96] Minn. Stat. § 626.5572, subd. 17.

11. The Department's assessment of a fine of one thousand dollars does not comply with Minn. Stat. § 245A.07, subd. 3(b)(4).

Based upon the foregoing Conclusions, and for the reasons set forth in the accompanying Memorandum, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED: that the determination of maltreatment and the decision of the Commissioner of Human Services fine Access of the Red River Valley, Inc. $1,000.00 be REVERSED.

Dated: January 8, 2007

/S/ Steve M. Mihalchick
STEVE M. MIHALCHICK
Administrative Law Judge

Tape recorded (10 tapes)
No Transcript Prepared

MEMORANDUM

The Department characterized the issues as: 1) what amount of supervision did the VA require; and 2) what amount of supervision was Access providing the VA.[97] Access maintains that there was no maltreatment of the VA and the Department's position amounts to claiming maltreatment for the reasonable exercise of judgment. Access maintains that there was no basis for any finding of neglect that could support finding that Access maltreated R.B.

R.B.'s case manager noted that the goal of placement was to obtain the least restrictive appropriate placement for persons in programs.[98] In furtherance of this goal, persons in programs are not moved into more restrictive settings without some demonstration of failure in the less restrictive setting. Up to the time that R.B. committed a sexual assault, his case manager believed that R.B. was appropriately placed.[99] The Department's finding of maltreatment and imposition of a fine must be assessed in the context of R.B.'s placement, not some other placement that could have been instituted.

[97] Tape 1, Side 1.
[98] Testimony of Lehman, Tape 3, Side 2.
[99] Testimony of Lehman, Tape 4, Side 1.

Maltreatment

The Department made a determination that Access committed maltreatment under Minn. Stat. § 626.5572, subd. 15. That determination relies upon a demonstration that the facility committed neglect. As defined in statute, neglect means:

> (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
>
> (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
>
> (2) which is not the result of an accident or therapeutic conduct.[100]

Under the circumstances of this matter, the only arguable basis for finding neglect is that Access failed to provide adequate supervision of R.B. To make a finding of neglect on that basis, the level of supervision that is "reasonable and necessary" to "maintain the vulnerable adult's physical or mental health or safety" has to be lacking.

Reasonable Supervision

The Department has not identified any aspect of R.B.'s physical health, mental health, or safety that was actually put at risk by having only one staffer working on the evening of January. At the hearing, the DHS investigator explained that the Department considered having double staffing could help avoid the possibility that R.B. could be harmed should a staffer have to act in self-defense. In the Department's posthearing arguments, the lack of supervision when K.M. left the site to receive medical care to address the sexual assault by R.B. is also cited as a reason why failure to provide double staffing constitutes neglect.

The Department cites R.B.'s attack on Duke and threatening behavior toward staff as evidence that double staffing was the appropriate level of supervision for R.B.[101] These are not instances of harm to R.B. These behaviors do underscore the difficulties inherent in placing VAs with impulse control problems in a least restrictive environment, which is an overall goal of the Department. There is no identified combination of staff members with whom Access could have staffed R.B.'s site who were physically capable of preventing R.B. from committing an assault on any staffer. The Department's assertion that having two staff members present was needed to protect R.B. is contradicted by the record in this matter and unsupported by any evidence in the record.

[100] Minn. Stat. § 626.5572, subd. 17.
[101] DHS Memorandum, at 2-6.

On January 2, 2004, R.B. was being supervised by K.M. K.M. was awake and alert. With the difference in size and physical strength between these two individuals, K.M. could not have physically stopped R.B. from committing an assault. None of the other staffers who worked with R.B. for Access could have physically stopped R.B. from committing that assault. This fact is demonstrated in this record by R.B.'s assault on Duke on November 10, 2003. Two staffers were present, yet R.B. assaulted and injured Duke. The "adequacy" of staffing levels made no difference in the outcome.[102]

Even in a more restrictive setting, R.B. was capable of committing misconduct. R.B.'s inappropriate touching of a female staffer at the Fergus Falls RTC resulted in R.B.'s probation being revoked. The record in this matter demonstrates that the level of supervision provided to R.B. on January 2, 2004 was adequate to protect R.B.'s physical or mental health or safety which is the legal standard required of Access. While the supervision provided to R.B. was inadequate to protect Duke on November 10, 2003, and K.M. on January 2, 2004, neither of those persons are VAs and the injuries that these staffers suffered do not trigger the statutory protections of Minn. Stat. § 626.5572, subds. 15 and 17.

The Department's argument that staff leaving the site resulted in inadequate supervision is also unsupported by the record. R.B.'s Behavior Intervention Plan explicitly directed staff to leave the site in the event that staff was unable to redirect behavior that was physically threatening. The Behavior Intervention Plan did not indicate that one staffer was to stay behind if R.B. was engaging in threatening behavior. Once in a safe situation, either in the staff room or away from R.B.'s apartment, staff would call for assistance, either to the Access on-call person or to law enforcement. After being assaulted, K.M. left the site, and dialed the on-call number for Access.[103] Upon receiving medical care, K.M.'s situation was conveyed to law enforcement and R.B. was taken into custody. Access cannot be cited for failure to supervise when the staffer's conduct was in accordance with the directions given in the Behavior Intervention Plan.

The Department also cited the opinion of Dr. Sand regarding R.B.'s placement as suggesting that existing supervision was inadequate. Dr. Sand did not exercise his power to institutionalize R.B. at the time of R.B.'s medical examination on November 3, 2003. Dr. Sand noted "The possibility that he [R.B.] would need even a more structured environment with more controls was

[102] The Department also cited the December 3, 2003 incident where R.B. falsely claimed to have been drinking cleaning products as demonstrating inadequate staffing levels. DHS Memorandum, at 6-7. But two staffers were present at that time. The Department's own description of the December 16, 2003 incident also appears to recognize this fact. DHS Memorandum, at 8-9.

[103] The call was not answered, but there is no evidence in the record as to why there was no answer. That two Access staffers responded and that they arrived before the police suggests that a voicemail message had been left by K.M.

tentatively broached with staff personnel and this is something we will have to see whether or not this is an adequate living situation for him."[104] The notation does not constitute a medical finding that more supervision was reasonable or necessary.

Staffing Decisions

Double staffing was instituted as a means of addressing inappropriate behaviors by R.B. that arose in November 2003. The experience with R.B. and double staffing was not successful. Only two weeks into that change in supervision, the direct care staff informed Access supervisors and the scheduler that double staffing resulted in bad behaviors by R.B. The reason for double staffing was to ensure that R.B. was complying with the specifics of his care plan. The Department has asserted that double staffing was necessary to protect staffers. Protection of staffers is beyond the scope of Minn. Stat. § 626.5572, subd. 17. The Department described double staffing as "proven necessary" due to the December 16, 2003 incident.[105] The Department did not identify any harm to R.B. that could have arisen from that incident, beyond R.B. not being supervised for a brief period of time, and that lack of supervision was in full compliance with R.B.'s Behavior Intervention Plan.

Access had experience with clients who pose a risk of harm to staff. On a prior occasion, Staton discharged a client from the Access program because that client was seen to pose and unacceptable risk to staff. Staton did not discharge R.B. from the Access program due to her perception that R.B. was redirectable in his behaviors.[106]

There was some suggestion that Access wanted R.B. returned to its program for financial reasons. There is no support for this contention in the record. There is significant evidence in the record to show that R.B. was at risk in his time away from the Access program, that R.B.'s mother was not able to manage R.B.'s blood sugar, and that R.B. wanted to go out to bars without supervision. The consistent testimony of the witnesses was that R.B. returned to the Access program unexpectedly, that there were not sufficient staff available to double staff the site, and that the staffers who were working with R.B. had expressed a preference for working alone with R.B.

Part of the Department's contention that double staffing was a reasonable and necessary level of supervision was the absence of an assessment team meeting to specifically approve a return to single staffing. But there was no assessment team meeting to approve double staffing either. The only meeting at which double staffing was discussed and initiated was not an assessment team meeting, it was an Access staff meeting. R.B.'s case manager testified that he approved the double staffing as a short term measure to address R.B.'s

[104] Ex. 14.
[105] DHS Memorandum, at 14.
[106] Testimony of Staton, Tape 9, Side 2.

behaviors and the case manager expected that double staffing would be discontinued when appropriate. The feedback from the Access direct care staff working with R.B. indicated that single staffing was preferable when dealing with R.B.

Summary

The Department relies on there being one staff member on duty when K.M. was sexually assaulted to demonstrate that there was some form of neglect to support the finding of maltreatment. The argument advanced by the Department is that understaffing could result in harm to a VA. The Department specifically noted the November 10 choking incident as the sort of incident where the VA could be injured. This argument overlooks the fact that two staffers were present during the choking incident. The facts of this matter demonstrate that R.B. was capable of committing assault, even if two staffers were present. Single staffing on the night of the sexual assault does not amount to a failure of supervision.

The Department seems to infer that harm to the VA arose from his conviction and incarceration. R.B. was criminally charged for the choking incident and convicted of assault. That incident occurred with two staffers present. The level of supervision made no difference in the effect on R.B.'s behavior. Even after R.B. had been convicted of sexual assault, his behavior did not change. R.B.'s probation was revoked for inappropriately touching a female staffer at the Fergus Falls RTC. Being held accountable for one's own criminal conduct does not constitute harm to a VA within the meaning of Minn. Stat. § 626.5572, subd. 17(a)(1).

There is no evidence in the record of this proceeding that R.B. was harmed by insufficient supervision. R.B. was physically capable of harming staff whether one staff member or two were present. All the evidence available to Access at the time of the sexual assault showed that R.B. had a good relationship with K.M., that he did not engage in extreme behaviors with K.M., and that he generally complied when K.M. redirected his inappropriate behaviors. The purpose of having two staff members was to ensure that R.B. did not harm himself by engaging in self-destructive behavior. The supervision available at the time of the sexual assault was adequate for the purpose for which it was provided. Accordingly, the Administrative Law Judge concludes that the Department has not demonstrated by a preponderance of the evidence that maltreatment through neglect occurred. In the absence of a maltreatment finding, there is no basis for assessing a fine.

S.M.M.